Sadler Health Center

(Office use Account #_____)

Dental Department Adult Health History

Date: _____

Patient Name: _____ Date of Birth: _____

Emergency Contact: _____ Emergency Contact Number: _____

Medical Doctor (Name, address, phone number): _____

Date of last physical: _____

Please list any medications (prescription or over the counter), vitamins, or supplements you are taking:

Please list all allergies and reactions:

Have you been hospitalized for care or surgery? If yes, list reasons:

Have you been treated for cancer, had chemotherapy, or had radiation treatment? If yes, list type and reason:

Have you ever been told you need antibiotic premedication before dental appointments?... Yes ☐ No ☐

Have you ever taken any bisphosphonates or medication for osteoporosis?..... Yes ☐ No ☐

Have you ever had any serious complications with dental treatment? .....Yes ☐ No ☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING CONDITIONS? Check YES, NO, DON'T KNOW

	YES	NO	DK
Headaches/Migraines	☐	☐	☐
History of Stroke	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐
Sleep Apnea	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
History of Heart Attack	☐	☐	☐
Heart Failure	☐	☐	☐
Atrial Fibrillation	☐	☐	☐
Pace Maker	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Asthma	☐	☐	☐
COPD	☐	☐	☐

	YES	NO	DK
Emphysema	☐	☐	☐
Bronchitis	☐	☐	☐
History of Tuberculosis	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
HIV or AIDS	☐	☐	☐
Kidney Problems	☐	☐	☐
Hepatitis A, B, or C	☐	☐	☐
Liver Problems	☐	☐	☐
Anemia	☐	☐	☐
Blood Disorders	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
Ulcers	☐	☐	☐
Acid reflux	☐	☐	☐

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Health and Education for Everyone

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	YES	NO	DK
Rheumatoid Arthritis	☐	☐	☐
Osteoarthritis	☐	☐	☐
Joint Replacement	☐	☐	☐
Osteoporosis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Muscular Disease	☐	☐	☐

	YES	NO	DK
Depression	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Schizophrenia	☐	☐	☐
Addiction/Recreational Drug Use	☐	☐	☐

Women

Are you pregnant? ☐ ☐ ☐ Due date? _____

Are you nursing? ☐ ☐ ☐

Please list any disease, condition, or problem not listed above:

Dental History

Who was your previous dentist? _____

When was your last dental exam and xrays? _____

When was your last cleaning? _____

What is the reason for your dental visit today?

Check YES, NO, DON'T KNOW.

	YES	NO	DK
Do your gums bleed?	☐	☐	☐
Do you have loose teeth?	☐	☐	☐
Are your gums swollen or tender?.	☐	☐	☐
Have you had any gum surgery?	☐	☐	☐
Do you wear dentures?	☐	☐	☐

	YES	NO	DK
Interested in getting dentures?	☐	☐	☐
Have you ever had braces?	☐	☐	☐
Do you clench or grind?	☐	☐	☐
Complications after extractions?	☐	☐	☐
Problems with local anesthesia?	☐	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or missing information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient/Guardian Signature Date

_____ _____

Dentist/Hygienist Signature Date